

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE - NATIONAL INSTITUTES OF HEALTH

NRSA SPECIAL ACTION / CHANGE NOTICE

TO: NRSA PROCESSING OFFICE
ROOM 105, WESTWOOD BUILDING

NAME OF FELLOW/TRAINEE

GRANT NUMBER

This form will be used to report **EXTENSIONS, BREAKS-IN-SERVICE**, and **WAIVERS** approved by the ICDs in connection with required Payback Service. Where necessary, it will also be used to report ICD initiation of FINANCIAL PAYBACK action and other pertinent changes.

DATE

INST/DIV CONTROL NUMBER

NAME OF PERSON COMPLETING FORM

PHONE NO.

TYPE OF ACTION (Check box and complete section)

☐

EXTENSION OF TIME TO BEGIN SERVICE

DATE PAYBACK SERVICE
IS TO BEGIN (015)

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

DATE OF ICD APPROVAL
(021)

☐

BREAK IN SERVICE

DATE PAYBACK SERVICE
IS TO BE RESUMED (015)

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

DATE OF ICD APPROVAL
(021)

☐

FINANCIAL PAYBACK (020) (2)

DATE OF TURNOVER TO DFM
FOR COLLECTION (022)

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

☐

WAIVER (020)

REASONS FOR WAIVER (Check one):

- ☐ (3) Disability
☐ (4) Hardship
☐ (5) Death
☐ (6) Other

DATE OF BOARD APPROVAL
(021)

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

NOTIFICATION OF CHANGE OF ADDRESS

Line 1 (009)

Line 2 (010)

Line 3 (011)

OTHER CHANGES (Itemize)